

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17494

CERTIFICATE OF DEATH

17486

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>26 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Md. 20014</u>				d. STREET ADDRESS <u>4208 Matthews Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Mary Frances Saccardi</u>				4. DATE OF DEATH <u>December 31</u> 19 <u>66</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11 June 1959</u>		
9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		
13. FATHER'S NAME <u>Donald A. Saccardi</u>				14. MOTHER'S MAIDEN NAME <u>Mary K. Davis</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Md. 20014</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>754.2</u> IMMEDIATE CAUSE (a) <u>Probable Ventricular Bradycardia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Pacemaker Failure</u> DUE TO (c) <u>Ventricular septal defect and complete heart block</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>30 minutes</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (A) (this hospital) attended the deceased from <u>December 31, 1966</u> , to <u>Dec. 31</u> , 19 <u>66</u> that (A) (we) last saw the deceased alive on <u>December 31</u> 19 <u>66</u> , and that death occurred at <u>12:27M</u> , from causes and on the date stated above.								
22a. SIGNATURE <u>Lawrence I. Bonchek</u> M.D.				22b. DATE SIGNED <u>Dec. 31, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Lawrence I. Bonchek, MD</u>		
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>				22e. REC'D BY REGISTRAR <u>Charles Judge</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>		
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, 5130 Wis. Ave. NW</u>				24b. ADDRESS <u>Washington, D.C.</u>		24c. REC'D BY REGISTRAR <u>Charles Judge</u>		

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Hospital attended 11/20/66 thru 12/24/66 and out-patient 12/26&28. Dr. John Ballou D.M.E. notified and approved.

MEDICAL CERTIFICATION

17488

CERTIFICATE OF DEATH

17488

Name of Deceased		Date of Death	
Sex		Age	
Place of Birth		Date of Birth	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17495

CERTIFICATE OF DEATH

17487

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
c. LENGTH OF STAY IN 1b <i>2 days</i>		d. STREET ADDRESS <i>6113 Lone Oak Drive</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Stephanie A Sacks</i>		4. DATE OF DEATH Month <i>12</i> Day <i>15</i> Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 9 1961</i>
9. AGE (In years last birthday) <i>5</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Washington D.C</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Walter F Sacks</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Schoenig</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr Walter F Sacks</i>		Address <i>same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mumps Encephalitis</i> DUE TO (b) <i>Viral parotitis, Pancreatitis & oophoritis</i> DUE TO (c) <i>1 week</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 13</i> , 1966, to <i>Dec 15</i> , 1966; that (I) (we) last saw the deceased alive on <i>Dec 15</i> , 1966, and that death occurred at <i>5:13</i> P.M. from causes on and on the date stated above.			
22a. SIGNATURE <i>James A Davis Jr.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>JAMES A DAVIS JR.</i>		22d. ADDRESS <i>8218 Wisconsin Ave, Beth Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-17-66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 23 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13493

PROSTATECTOMY

82

PROSTATECTOMY

1. Name of patient: [illegible]

2. Age: [illegible]

3. Sex: [illegible]

4. Date of operation: [illegible]

5. Name of surgeon: [illegible]

6. Name of assistant: [illegible]

7. Name of anesthesiologist: [illegible]

8. Name of operating room: [illegible]

9. Name of hospital: [illegible]

10. Name of city: [illegible]

11. Name of state: [illegible]

12. Name of zip code: [illegible]

13. Name of telephone number: [illegible]

14. Name of fax number: [illegible]

15. Name of e-mail address: [illegible]

16. Name of website: [illegible]

17. Name of social media: [illegible]

18. Name of other contact information: [illegible]

19. Name of other contact information: [illegible]

20. Name of other contact information: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17496											
Item 2 Film G384 12/30/66 mh											
17488											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u> c. LENGTH OF STAY IN 1b <u>3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MARYLANDER HOME OF REST, INC.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>MONTG.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u> d. STREET ADDRESS <u>Waters Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ALICE</u> First <u>LORETTA</u> Middle <u>SCHAEFFER</u> Last			4. DATE OF DEATH <u>Dec</u> Month <u>21</u> Day <u>1966</u> Year								
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 13, 1902.</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>FRED. County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FREDERICK VALENTINE</u>						14. MOTHER'S MAIDEN NAME <u>BERTHA WHITMORE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>P. Saville L.P.N.</u> Address <u>Germantown, md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>444X</u> DUE TO (b) <u>Pulmonary embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Advanced obscure atherosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>48 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Hypertension</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January, 1948</u> to <u>Dec 21, 1966</u> , that (I) (we) last saw the deceased alive on <u>20 Dec 1966</u> , and that death occurred at <u>7:45 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>John G. Fawcett</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>12/21/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>John G. Fawcett</u>						22d. ADDRESS <u>Dawsonsville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Dec. 24, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u>			23d. LOCATION (City, town or county) <u>Rocky Ridge, Md.</u> (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Molesworth,</u> ADDRESS <u>Damascus, Md.</u>						25a. REC'D BY REGISTRAR <u>DEC 28 1966</u> DATE			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

13492

STATE OF TEXAS

13492

13492

13492



17497

CERTIFICATE OF DEATH

17489

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEYV CHASE, MD</u>		c. LENGTH OF STAY IN 1b <u>9 MOS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SIL. Sp. MD.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BETHESDA - SIL. Sp. Nurs. Home</u>				d. STREET ADDRESS <u>8201 16th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ETHEL MARGOLIS SCHERR</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>26</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1/25/1882</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MORDECAI MARGOLIS</u>				14. MOTHER'S MAIDEN NAME <u>PEARL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MISS HEORALOTH SCHERR - 1401 Blain M Rd SEAG</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>199.2 IMMEDIATE CAUSE (a) UNDIFFERENTIATED INTRAABDOMINAL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>METASTATIC CARCINOMA</u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic heart disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u>59</u> , to <u>12-26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-22</u> 19 <u>66</u> , and that death occurred at <u>7 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Herbert L. Tanenbaum</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Herbert L. TANENBAUM</u>				22d. ADDRESS <u>4400 Conn Ave NW WASH DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/28/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Wash. DC</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>				ADDRESS <u>4217 92nd St. NW</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 28 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15851

3223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17498					17499						
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			c. LENGTH OF STAY IN 1b 22 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington 15.1						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4311 Clearbrook Lane					d. STREET ADDRESS 4311 Clearbrook La.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALICE Middle K Last SCHLEGEL			4. DATE OF DEATH 12/10 1966		4. DATE Month Day Year						
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 Oct. 1869		9. AGE (In years last birthday) 97 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (County & State, or foreign country) Ohio			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Kraus					14. MOTHER'S MAIDEN NAME Margaret Snyder						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. W.A. McDowell item 2, daughter						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) OBSTRUCTIVE PNEUMONITIS, RT. LUNG (c) PROBABLE NEOPLASM PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 2 MONTHS 6 MONTHS											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from FEB 4, 1949, to DEC 10, 1966, that (I) (we) last saw the deceased alive on DEC 9, 1966, and that death occurred at 2 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Robert G. Angell					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED DEC 10, 1966				
22c. PHYSICIAN'S NAME (Type) Robert G. Angell					22d. ADDRESS 5009 Delray Ave. Bethesda, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF 12/12/1966		23c. NAME OF CEMETERY OR CREMATORY Oak Hill		23d. LOCATION (City, town or county) (State) Millersburg Ohio				
24. FUNERAL DIRECTOR Jos. Gawler's Sons 5130 Wisconsin Ave. N.W Wash. DC					25a. REC'D BY REGISTRAR DEC 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

13100

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

17499

CERTIFICATE OF DEATH

17491

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Wash.</u> b. COUNTY <u>DC</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. LENGTH OF STAY IN lb <u>2 YR, 3 mo.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> <u>47.3</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC VALLEY NURSING Home</u>		d. STREET ADDRESS <u>5112 Conn. Ave. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>PAULINE F. SCHMIDT</u>		4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 19, 1874</u> <u>92</u> yrs.
9. AGE (In years lost birthday)		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Charles L. Hills</u>	
14. MOTHER'S MAIDEN NAME <u>Bertha Hills</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>577-48-0106A</u>		17. INFORMANT <u>Lindley G. Schmidt, Husb., Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>24 hrs</u> <u>Indef</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>gen. arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/22, 1965</u> to <u>12/30, 1966</u> that (I) (we) last saw the deceased alive on <u>12/30, 1966</u> and that death occurred at <u>9:45</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen M. Jones</u>		22b. DATE SIGNED <u>12/31/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN M JONES</u>		22d. ADDRESS <u>Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>JAN 9 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

15222

RECEIVED OF CLARK

13404

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17500					17492				
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Asbury Methodist Home for the Aged, Inc.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY 85.3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shepherdstown d. STREET ADDRESS Rolling Acres Gaithersburg, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Lucy Harris Schoppert			4. DATE OF DEATH Month Day Year December 26 1966		5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH Aug. 8- 1870			9. AGE (In years last birthday) 96 yrs. IF UNDER 1 YEAR Months 4 Days 18 IF UNDER 24 HRS. Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kept house			10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Shepherdstown, West Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME John H. Schoppert					14. MOTHER'S MAIDEN NAME Eliza Harris				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Bronchopneumonia DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 18 days 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7/63 , 19 63 , to 12/26/66 , that (I) (we) last saw the deceased alive on 12/26/66 , and that death occurred at 6:27 AM , from the causes and on the date stated above.									
22a. SIGNATURE Henry C. Scruggs, M.D.			22b. DATE SIGNED 12/26/66		22c. PHYSICIAN'S NAME (Type) Henry C. Scruggs, M.D.				
22d. ADDRESS 5413 Cedar Lane Bethesda Md.			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-28-66		23c. NAME OF CEMETERY OR CREMATORY Elmwood Assoc.		23d. LOCATION (City, town or county) (State) Shepherdstown W. Va.		
24. FUNERAL DIRECTOR Ernest C. Gartner			ADDRESS Asbury Methodist Home, Gaithersburg, Md.		DATE 12/29/1966		25. REGISTRAR'S SIGNATURE Charles Judge		

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CERTIFICATE OF DEATH

17493

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium				d. STREET ADDRESS 3051 Porter Street N.W.			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last SCHROEDER				4. DATE OF DEATH Month 12 Day 7 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/17/1889	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Store			10b. KIND OF BUSINESS OR INDUSTRY Iowa		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		
13. FATHER'S NAME William H. Schroeder				14. MOTHER'S MAIDEN NAME Anna P.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) <input type="checkbox"/>			16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT Gertrude E. Schroeder same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause } (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cholecystitis with recent exacerbation						INTERVAL BETWEEN ONSET AND DEATH 30 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 , to December 7, 1966 , that (I) (we) last saw the deceased alive on December 7, 1966 , and that death occurred at 5 PM , from the causes and on the date stated above.							
22a. SIGNATURE Florentino P. Palmon Jr M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) FLORENTINO P. PALMON, JR. MD.				22d. ADDRESS 2121 PENNSYLVANIA AVE N.W., D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF 12/8/66		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory Prince Georges County, Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				25a. REC'D BY REGISTRAR DEC 9 1966		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

13400

13500

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

17502

17494

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	c. LENGTH OF STAY IN 1b 15 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 1501 DUBLIN DRIVE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARTHA Middle Jane Last SENECA		4. DATE OF DEATH Month 12 Day 13 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/28
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months 12 Days 13 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (County & State, or foreign country) Charlestown, Ind.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Marion Carr	
14. MOTHER'S MAIDEN NAME Margaret Prather		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None	
16. SOCIAL SECURITY NO. yes		17. INFORMANT Victor J Seneca	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Metastatic Adenocarcinoma Lung Primary Unknown DUE TO (c) 6 mos.		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 66 , to Dec 13 , 19 66 , that (I) (we) last saw the deceased alive on Dec 12 , 19 66 , and that death occurred at 8 A M, from causes and on the date stated above.			
22a. SIGNATURE James W. Egan		22b. DATE SIGNED 12-13-66	
22c. PHYSICIAN'S NAME (Type) James W. Egan		22d. ADDRESS 5413 Cedar La., Beth., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 17, 1966	
23c. NAME OF CEMETERY OR CREMATORY Charlestown Cemetery		23d. LOCATION (City or Town) (County) (State) Charlestown, Indiana	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE DEC 20 1966	

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1376

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17503

CERTIFICATE OF DEATH

17495

1. PLACE OF DEATH a. COUNTY <u>MONT COMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN lb <u>4 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 15</u>		d. STREET ADDRESS <u>8415 Dixon Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>E</u> Last <u>SEVILLE</u>		4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-86</u>
9. AGE (In years lost birthday) yrs. <u>80</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Bramble</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Cecelia Frost</u>		Address <u>8415 Dixon Avenue Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Congestive failure</u> DUE TO (b) <u>My peristent Cardiovascular Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>years -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> , 19 <u>66</u> , to <u>Dec 2</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Dec 2</u> 19 <u>66</u> and that death occurred at <u>1:35 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>George Shaye</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>George Shaye</u>		22d. ADDRESS <u>10400 Conn. Ave., Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 6, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>DEC 8 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	

13493

RECEIPT OF DEBIT

13493

DATE		1941	
NO.		13493	
NAME		J. H. HARRIS	
ADDRESS		1234 MAIN ST.	
CITY		NEW YORK	
STATE		N.Y.	
ZIP		10001	
AMOUNT		100.00	
BALANCE		100.00	
TOTAL		100.00	
REMARKS		PAID TO J. H. HARRIS	
DATE		1941	
NO.		13493	
NAME		J. H. HARRIS	
ADDRESS		1234 MAIN ST.	
CITY		NEW YORK	
STATE		N.Y.	
ZIP		10001	
AMOUNT		100.00	
BALANCE		100.00	
TOTAL		100.00	
REMARKS		PAID TO J. H. HARRIS	

FOR STATE HEALTH DEPT.

17504

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17496

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b <u>16 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> <u>15.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>214 DALE DR.</u>				d. STREET ADDRESS <u>214 DALE DR.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET LOUISE SHAFER</u>				4. DATE OF DEATH Month Day Year <u>12 - 13 19 66</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sep. 6, 1915</u>		
				9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Highspire, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Fred Patton</u>				14. MOTHER'S MAIDEN NAME <u>Myrtle Will</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>			16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Ernest C. Shaffer</u> Address <u>214 Dale Drive Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure due to</u> DUE TO (b) <u>carbon monoxide poisoning</u> DUE TO (c) <u>lost.</u>							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased connected garden hose from exhaust into car vent window.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>2:00</u> <u>12-12</u> <u>19 66</u> <u>p.m.</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home (Garage)</u>			
					20f. (City or town) (County) (State) <u>Silver Spring Mont. Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Belden R. Phipps, M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED <u>Dec. 12, 1966</u>		
EXAMINER'S NAME (Type) <u>BELDEN R. Phipps M.D.</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 16, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>		
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>			ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15330

15330

RECEIVED
JAN 19 1962
U.S. GOVERNMENT PRINTING OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
17505					17497					
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 41 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seat Pleasant 16.2					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					d. STREET ADDRESS 12 Dainler Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Lisa Middle Patricia Last Shannon			4. DATE OF DEATH Month December Day 12 Year 1966							
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 February 1965		9. AGE (In years last birthday) 1 yrs. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Leonard Shannon					14. MOTHER'S MAIDEN NAME Dorothy Brown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address The Medical Record, National Institutes of Health, Clinical Center, Bethesda, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest secondary to hypoxia 467.2 DUE TO pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Superior vena caval obstruction syndrome and / and pulmonary atresia DUE TO (c) Postoperative superior caval shunt for tricuspid INTERVAL BETWEEN ONSET AND DEATH 1 hour 48 hours 120 hours										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) Gastrointestinal hemorrhage secondary to stress ulcer / (2) Cerebral edema									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1 November , 19 66 , to 12 December , 19 66 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12 December , 19 66 , and that death occurred at 9:35 AM from the causes and on the date stated above.										
22a. SIGNATURE R. Darryl Fisher, MD					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED December 12, 1966		
22c. PHYSICIAN'S NAME (Type) R. Darryl Fisher, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 12-16-66		23c. NAME OF CEMETERY OR CREMATORY OAK GROVE CEMETERY			23d. LOCATION (City, town or county) (State) ELIZABETH CITY, N.C.		
24. FUNERAL DIRECTOR W.H. JONES JR.					25a. REC'D BY REGISTRAR WALSON FUNERAL HOME, ELIZ. CITY, N.C.					25b. REGISTRAR'S SIGNATURE Charles Judge

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17506

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17498

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	c. LENGTH OF STAY IN lb <u>8 hrs 45 min</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>9310 WIRE AVE.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE E. SHEAHAN</u>		4. DATE OF DEATH Month Day Year <u>12 10 19 66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-8-06</u>
9. AGE (In years lost birthday) <u>60 yrs.</u>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Thomas Sheahan</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen McCabe</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>Dec. 10, 1966</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/13/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Int Olivet</u>
23d. LOCATION (City or town) (County) (State) <u>Wash. DC</u>		23e. REC'D BY REGISTRAR <u>DEC 13 1966</u>	
23f. REGISTRAR'S SIGNATURE <u>Wm Tattarull</u>		23g. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

Rechts der Willkür

(1) *Chrysomelidae* (2) *Chrysomelidae*
 (3) *Chrysomelidae* (4) *Chrysomelidae*

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

17507

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17499

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1-DAY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 15.1	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fanny Matilda Shelley</u>		4. DATE OF DEATH Month Day Year <u>12 23 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <u>7-2-87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>
13. FATHER'S NAME <u>William Jordan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war & dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest secondary to</u> 433.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>arrhythmia of unknown etiology</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/26/66m</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Myrtle Green Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Columbus County, N.C.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25a. RECEIVED BY REGISTRAR <u>DEC 30 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		22. DATE SIGNED <u>12/23/1966</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13488

13503

19/03/1966

19/03/1966

19/03/1966

19/03/1966

17508

CERTIFICATE OF DEATH

17500

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft. Meade</u> 02.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>		d. STREET ADDRESS <u>7801 Boyce St.</u>	
3. NAME OF DECEASED (Type or print) <u>BABY GIRL</u> First Middle Last <u>Shelton</u>		4. DATE OF DEATH <u>December 11 1966</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 10, 1966</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>1 2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>DANNY LEE Shelton</u>		14. MOTHER'S MAIDEN NAME <u>DIANNE McCONNELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>DANNY L. Shelton</u>		Address <u>As Above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 750X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anomalous</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 10, 1966</u> to <u>Dec 11, 1966</u> that (I) (we) last saw the deceased alive on <u>Dec 10, 1966</u> , and that death occurred at <u>6:45 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Morris Feitel</u>		22b. DATE SIGNED <u>12-11-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORRIS FEITEL MD</u>		22d. ADDRESS <u>704 Janner Ave Land Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/13/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25. REG'D BY REGISTRAR <u>Rockville, Maryland</u>	
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		DATE <u>DEC 16 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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REMARKS OF DEATH

REMARKS OF DEATH

REMARKS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17510

17502

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY in lb 11 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sylvan Manor Health Care Center		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 10112 Portland Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nannie Middle Maria Last Simmons		4. DATE OF DEATH Month Dec Day 8 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1874
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander T. Bowen		14. MOTHER'S MAIDEN NAME Elizabeth Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Louise Simpson		Address 10112 Portland Place Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease (a), stating the underlying cause last. (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 4 years year?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from July 18, 1962 to Dec 8, 1966 , that (I) (we) last saw the deceased alive on Dec 7, 1966 , and that death occurred at 1301 AM , from the causes and on the date stated above.			
22a. SIGNATURE Neil P. Campbell M.D.		22b. DATE SIGNED 12/8/66	
22c. PHYSICIAN'S NAME (Type) Neil P. Campbell		22d. ADDRESS 1629 Col. Rd. Washington D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 10, 1966	
23c. NAME OF CEMETERY OR CREMATORY Central Cemetery		23d. LOCATION (City, town or county) (State) Barstow, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Glen Carter Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS 8434 Georgia Avenue Silver Spring, Md.		DATE DEC 14 1966	

17508

17510



1000 West 10th Street
Dallas, Texas 75201
Telephone: 754-1234

1000 West 10th Street

1000 West 10th Street

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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17511

DIVISION OF STATISTICAL

MARYLAND STATE DEPARTMENT OF HEALTH

RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17503

1. PLACE OF DEATH a. COUNTY: <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): <u>Silver Spring, Maryland</u> c. LENGTH OF STAY in 1b: <u>47.3</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): <u>Bella Vista Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE: <u>Maryland</u> b. COUNTY: <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): <u>Silver Spring, Washington</u> d. STREET ADDRESS: <u>738 Longfellow St. NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MRS. SLAYMAKER</u> First <u>Bessie</u> Middle <u>Bessie</u> Last <u>Bessie</u>		4. DATE OF DEATH: <u>12</u> <u>19</u> <u>66</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH: <u>1879 DEC. 25</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Government</u>	
11. BIRTHPLACE (County & State, or foreign country): <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Henry M. Burch</u>		14. MOTHER'S MAIDEN NAME: <u>Martha E. Burch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): <u>NO</u>		16. SOCIAL SECURITY NO.: <u>579-60-0588</u>	
17. INFORMANT: <u>Mrs. Mildred O. Regan</u>		Address: <u>1007 Nora Drive, Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Cardio Vascular Renal Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 Hrs</u> <u>5 Yrs</u> <u>8 Yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> , to <u>12/19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/12</u> , 19 <u>66</u> , and that death occurred at <u>5A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE: <u>Harold Heiges</u>		22b. DATE SIGNED: <u>12/19/66</u>	
22c. PHYSICIAN'S NAME (Type): <u>HAROLD HEIGES</u>		22d. ADDRESS: <u>1835 Eye St NW DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		23b. DATE THEREOF: <u>12/21/66</u>	
23c. NAME OF CEMETERY OR CREMATORY: <u>FORT LINCOLN</u>		23d. LOCATION (City, town or county) (State): <u>BLADENSBURG, MD</u>	
24. FUNERAL DIRECTOR: <u>W.W. CHAMBERS CO.</u>		25a. REC'D BY REGISTRAR: <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE: <u>Charles Judge</u>	
ADDRESS: <u>8655 G.H. AVE SILVER SPRING, MD</u>		DATE: <u>DEC 21 1966</u>	

17508

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17512

CERTIFICATE OF DEATH

17504

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida		b. COUNTY ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 127 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pensacola		48-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland				d. STREET ADDRESS 5915 Count Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna		First Anna		Middle (None)		Last Smeeton	
4. DATE OF DEATH December 9 1966		Month December		Day 9		Year 1966	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 January 1916	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 0		Oays 0		IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (County & State, or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Sterk				14. MOTHER'S MAIDEN NAME Nellie Volkema			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 524-14-2063		17. INFORMANT The Medical Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest 2000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Reticulum Cell Sarcoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sjogren's Syndrome, / Sicca variety		INTERVAL BETWEEN ONSET AND DEATH 5 Mins. 4 Months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4 August , 1966, to 9 Dec. , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9 December 1966 , and that death occurred at 12:40 , from the causes and on the date stated above.							
22a. SIGNATURE David N. Soghor				M.O. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/9/66	
22c. PHYSICIAN'S NAME (Type) David N. Soghor, MD.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial-transit 12-11-66		Barrancas Natl Cemetery, Pensacola, Florida		DEC 15 1966		Charles Judge	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR DEC 15 1966			

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17513					17505				
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) W. Hyattsville 16.2				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington San. & Hosp.					d. STREET ADDRESS 6911 - 17th Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edgar Middle Last Smith			4. DATE OF DEATH Month 12 Day 15 Year 19 66						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/4/1885		9. AGE (in years last birthday) 81 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs. Edith Smith (above address) (wife)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Myocardial Infarction Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) Coronary Thrombosis DUE TO (c) Coronary atherosclerosis								INTERVAL BETWEEN ONSET AND DEATH minutes minutes year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of larynx (treated)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1962, to 12-15, 1966, that (I) (we) last saw the deceased alive on November 1966, and that death occurred at M, from the causes and on the date stated above.									
22a. SIGNATURE Donald C. Edgren			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-16-66				
22c. PHYSICIAN'S NAME (Type) Donald C. Edgren			22d. ADDRESS Pr. Geo. Plaza, Hy., Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/19/66		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Com.			23d. LOCATION (City, town or county) (State) Hyattsville, Md.		
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR DATE DEC 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Handwritten notes and signatures, including "C. J. ...", "C. J. ...", and "C. J. ...".

17514

CERTIFICATE OF DEATH

17506

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>10800 GEORGIA AVE. APT. 214</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10800 GEORGIA AVE. APT. 214</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Cecelia Smith</u>		4. DATE OF DEATH Month Day Year <u>Dec. 29 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-18-83</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Orson School</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Orson, Pa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S</u>	
13. FATHER'S NAME <u>Thomas L. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane O'Neill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-60-2718</u>	
17. INFORMANT <u>Sister Miss Rose Anne Smith</u>		Address <u>See Item No. 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Probable Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO (c) <u>last.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1958, 19</u> to <u>Dec 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 28, 1966</u> , and that death occurred at <u>2</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Elizabeth Chickering</u> M.D.		22b. DATE SIGNED <u>12-29-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth Chickering</u>		22d. ADDRESS <u>3601 Connecticut Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>12-31-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Pleasant Mount, Pa.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. DC.</u>		25a. REC'D BY REGISTRAR <u>JAN 3 1967</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1251

13206

17515

CERTIFICATE OF DEATH

17507

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>NONE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 1b <u>11 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS SANITARIUM</u>		d. STREET ADDRESS <u>1759 PARK RD. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>ROGER</u> Middle <u>B.</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 22, 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FURNITURE BUSINESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>	9. AGE (In years last birthday) <u>97</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>FREDERICH, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MILTON G. SMITH</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE GRIFFITH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>J. Blaine Fitzgerald</u>		Address <u>1759 Park Rd. N.W. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>6 weeks</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Squamous Cell Carcinoma - face.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October, 1966</u> to <u>December, 1966</u> , that (I) (we) last saw the deceased alive on <u>11/26</u> 19 <u>66</u> , and that death occurred at <u>145P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. Blaine Fitzgerald</u>		22b. DATE SIGNED <u>12/6/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. BLAINE FITZGERALD</u>		22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/9/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>W. W. Chandross Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>3655 Van Ness</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>DEC 9 1966</u>			

1350

CENTRAL ISLAND

1350



17516

CERTIFICATE OF DEATH

17508

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP - cleared with Medical Examiner

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>4 hours</u>		d. STREET ADDRESS <u>12244 VIERS MILL ROAD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First Middle Last <u>Talmadge SNEED</u>		4. DATE OF DEATH <u>12</u> Month <u>7</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 4 1922</u>
9. AGE (In years last birthday) <u>44</u> Yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not in same occupation) <u>CLERK - Tele. cations</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VETERANS Administration</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Atlanta Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Leonard J. Sneed</u>		14. MOTHER'S MAIDEN NAME <u>Nera E. Tyson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW II</u>		16. SOCIAL SECURITY NO. <u>419-16-7688</u>	
17. INFORMANT <u>Mrs. A. B. Wolfe</u>		Address <u>12244 Viers Mill Road Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>coronary thrombosis and atherosclerosis</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute pulmonary edema</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/4</u> , 19 <u>66</u> , to <u>12/7</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>12/7</u> , 19 <u>66</u> , and that death occurred at <u>10:45 AM</u> on the date stated above.			
22a. SIGNATURE <u>John J. Curry</u>		22b. DATE SIGNED <u>12/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John J. Curry, M.D.</u>		22d. ADDRESS <u>10620 Georgia Ave., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 10, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>DEC 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>8454 Georgia Ave. Silver Spring, Md.</u>	

01622

1358

Case No. 2181 of 1925

Journal of Management Education 32(1)

John J. O'Leary

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17517

CERTIFICATE OF DEATH

17509

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>2 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>5314-Heacia Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Oppa</u> Middle <u>To</u> Last <u>Snyder</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/3/192</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer H. McCarty</u>				14. MOTHER'S MAIDEN NAME <u>Elise Young</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Harold E. Snyder</u> Address <u>Bethesda</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, massive</u> DUE TO (b) <u>Coronary thrombosis, recent</u> DUE TO (c) <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Massive Gastrointestinal Hemorrhage</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1</u> , 19 <u>62</u> to <u>Dec</u> , 19 <u>66</u> that (I) (<u>we</u>) last saw the deceased alive on <u>Dec 18</u> 19 <u>66</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>James W. Egan</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12.19.66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES W. EGAN</u>				22d. ADDRESS <u>5413 Cedar Lane, Bethesda</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-26-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETH-EL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>CHEYENNE, WYOMING</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>BETHESDA, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 23 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12508

RECEIVED 12-19-66

12508

Massive Gastrointestinal Hemorrhage

12/19/66
243 Cohn Ave
Black

James W. [unclear]
12-19-66

Cleared - Dr. Reap

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17518

CERTIFICATE OF DEATH

17510

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		d. STREET ADDRESS <u>1401 Blair Mill Road Apt. 524</u>	
3. NAME OF DECEASED (Type or print) <u>Solomon</u> First <u>NMN</u> Middle <u>Spivock</u> Last		4. DATE OF DEATH Month <u>December</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 22, 1896</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sheet Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ROOFING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Spivock</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-46-7613</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute coronary thrombosis</u> DUE TO (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>5 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 28, 1966</u> to <u>Dec 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 28, 1966</u> , and that death occurred at <u>6:50 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Simon C. Weiner</u>		22b. DATE SIGNED <u>Dec 5, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Simon C. Weiner</u>		22d. ADDRESS <u>8201-16 4th St. Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>D.C. LODGE CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON D.C.</u>
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home 4217 9th St. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 7 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

13511

13518

CENTRAL OF DENVER

Washington
Solomon
White
K...

...

...

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17519

CERTIFICATE OF DEATH

17511

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		d. STREET ADDRESS <u>9115 Sudbury Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Martha</u> First <u>Tyler</u> Middle <u>Standiford</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/3/1884</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cinn. Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kern</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>219-348438</u>	
17. INFIRMANT <u>M. Kathryn Standiford</u>		Address <u>9115 Sudbury Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>"</u> (c) <u>"</u> DUE TO 3 wks			INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>November 14, 1966</u> , to <u>December 8, 1966</u> , that (I) (we) last saw the deceased alive on <u>December 7, 1966</u> , and that death occurred at <u>2:00</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Bennet A. Porter, Jr.</u> M.D.		22b. DATE SIGNED <u>December 8, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 10, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 14 1966</u>	

1471

01697

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17520

1. PLACE OF DEATH a. COUNTY Montg, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montg,	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 9 da,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph First Stang Last		4. DATE OF DEATH Month 12 Day 2 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 17-1888
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 15 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (County & State, or foreign country) Montg, Co. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph D. Stang		14. MOTHER'S MAIDEN NAME Mary Hanfann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W W-1		16. SOCIAL SECURITY NO. 578-07-3378	
17. INFORMANT Marie T. Stang.		Address As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bleeding Cerebral Arteriovenous Aneurysm			INTERVAL BETWEEN ONSET AND DEATH 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/23 , 19 66 , to 12/2 , 19 66 that (I) (we) last saw the deceased alive on 12/2 , 19 66 , and that death occurred at 1:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE Ernest C. Hartman		22b. DATE SIGNED 12/2/66	22c. PHYSICIAN'S NAME (Type) Ernest C. Hartman
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-6-66	23c. NAME OF CEMETERY OR CREMATORY St. Rose
23d. LOCATION (City or Town) (County) (State) Clopper Montg. Md.		24. FUNERAL DIRECTOR Ernest C. Hartman	
25. REC'D BY REGISTRAR DEC 6 1966		26. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15250

15251

STATE OF TEXAS



17521

CERTIFICATE OF DEATH

17513

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in lb <u>39 hours</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>8 Philadelphia Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Elmer Stauffer</u> First Middle Last 4. DATE OF DEATH <u>December 6 1966</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>12-17-86</u> 9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adrian Stauffer</u> 14. MOTHER'S MAIDEN NAME <u>Clara Bitler</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service) <u>NONE</u> 16. SOCIAL SECURITY NO. <u>199-05-5929-A</u> 17. INFORMANT <u>Records - Washington Sanitarium & Hospital</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive heart failure</u> DUE TO (b) <u>arteriosclerotic heart disease &</u> DUE TO (c) <u>old anterior infarction.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1965</u> to <u>Dec. 6 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 6 1966</u> , and that death occurred at <u>2:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John N. Andrews</u> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-6-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>		22d. ADDRESS <u>9601 Colesville Rd Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/9/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON</u>		23d. LOCATION (City or Town) (County) (State) <u>River Road - HATTIESVILLE MD.</u>	
24. FUNERAL DIRECTOR <u>W-W. Chambers, Inc. 512 S. P. MD.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>DEC 9 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

13251

13251

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Date of Death	
Place of Birth		Place of Death		Cause of Death	
Occupation		Marital Status		Burial Place	
Signature of Physician		Signature of Registrar		Signature of Witness	
Date of Certificate		Place of Issuance		Official Seal	

17522

CERTIFICATE OF DEATH

17514

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and finally event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>1 day/4 hrs/5 am.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>153 Galveston Pl. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>Elizabeth</u> Last <u>STEINER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 22, 1894</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H. Wife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wilmington Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew A Fulmele</u>		14. MOTHER'S MAIDEN NAME <u>Anna M Clancy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> 420.1 DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis Generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>10 yrs.</u> <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Acute Lymphatic Leukemia & Severe Anemia</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 16, 1966</u> to <u>December 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>December 2, 1966</u> , and that death occurred at <u>12:37 A.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Walcutt W. Gibson, M.D.</u>		22b. DATE SIGNED <u>Dec 2, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Walcutt W. Gibson, M.D.</u>		22d. ADDRESS <u>4300 5th, Barnabas Road</u> <u>Marlow Heights, Md. (Vic. D.R. 20031)</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-5-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Wheaton Maryland</u>
24. FUNERAL DIRECTOR <u>W. H. Hunter & Son</u>		25a. REC'D BY REGISTRAR <u>DEC 6 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17523

CERTIFICATE OF DEATH

17515

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>37 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>1420 HIGHLAND DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>Charles</u> Last <u>STELLO</u>		4. DATE OF DEATH Month <u>12</u> - Day <u>11</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/7/96</u>
9. AGE (In years lost birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt. Int. Rev. Washington, D. C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Stello</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Heitmuller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>578-46-6972</u>	
17. INFORMANT <u>Pearl J. Stello</u>		Address <u>1420 Highland Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Clear cell carcinoma of right kidney with lymph node metatases</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-15</u> , 19 <u>65</u> , to <u>12-11</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>12-10</u> , 19 <u>66</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>George F. Sengstack M.D.</u>		22b. DATE SIGNED <u>12-11-66</u>	22c. PHYSICIAN'S NAME (Type) <u>George F. Sengstack</u>
22d. ADDRESS <u>9241- Columbia Blvd. Silver Spring</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 14, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25. REC'D BY REGISTRAR <u>DEC 16 1966</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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18212

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17524 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17516

FOR STATE HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 1 Yr. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Clearfield Care Home 14326 New Hampshire Ave.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1619 Oakview Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Georgia Hay Stone		4. DATE OF DEATH Month Dec. Day 10 Year 1966		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH August 22 1979 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 87 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (State or foreign country) Indiana 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lewis Hay		14. MOTHER'S MAIDEN NAME Catherine Specht		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Mary Rathblum Address Same As #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Acute Pulmonary Edema 4200 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BELDEN R. REAP		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Washington D.C.		DATE SIGNED Dec. 10, 1966			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-13-66		22c. NAME OF CEMETERY OR CREMATORY Lee Crematory			
23. FUNERAL DIRECTOR J. Wm. Lees Sons		ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DATE DEC 14 1966			

17510

MEDICAL EXAMINATION CERTIFICATE OF DEATH

17510

THE SUB
WILLIAM



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17525				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				17517			
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN lb. <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. + Hospital</u>						d. STREET ADDRESS <u>1412 Hampshire W. Ct.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Grace ELIZABETH Stoner</u>						4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>3-15-06</u>		9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General Electric</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Mathew M. McKinney</u>						14. MOTHER'S MAIDEN NAME <u>Mabel Brown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>579-01-1226</u>		17. INFORMANT <u>Georgia O'Connell</u> Address <u>5500 New Hampshire Ave. Silver Spring, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute coronary thrombosis;</u> DUE TO (b) <u>Coronary artery heart disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						22. DATE SIGNED <u>12/16/1966</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Dec 19, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>434 Georgia Avenue Silver Spring, Maryland</u>						25. RECEIVED BY REGISTRAR <u>12/16/1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1551

1552

12/16/1966
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X X X X X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Item 23b Film G384 12/29/66 mh

17526

CERTIFICATE OF DEATH

17518

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 40 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annandale P3.3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 7857 Danby Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jacob Middle Brooks Last TAYLOR				4. DATE OF DEATH Month December Day 19 Year 19 66			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1920		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months 46 Days 46	IF UNDER 24 HRS. Hours 46 Min. 46
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Elizabethton, Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Everett Taylor				14. MOTHER'S MAIDEN NAME Jane C. Cole			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 229 05 1278		17. INFORMANT Annandale Address Virginia Mrs. Rose A. Taylor, 7857 Danby Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 177X IMMEDIATE CAUSE (a) Carcinoma prostate with metastases, peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (If (this hospital) attended the deceased from Nov. 9 , 19 66 , to Dec. 19 , 19 66 that (I) (we) last saw the deceased alive on Dec. 19 , 19 66 , and that death occurred at 8:35AM , from causes and on the date stated above.							
22a. SIGNATURE Edward C. Gilbert				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec. 20, 1966	
22c. PHYSICIAN'S NAME (Type) Edward C. Gilbert, M. D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 23, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Va.	
24. FUNERAL DIRECTOR Ives Funeral Home				ADDRESS 2847 Wilson Blvd. Arlington, Va.		25a. REC'D BY REGISTRAR DATE DEC 23 1966	
						25b. REGISTRAR'S SIGNATURE Charles Judge	

1935

1935

IN RE: OF DEATH

Virginia

Virginia

Virginia

Virginia (1935)

WEST VIRGINIA

WEST VIRGINIA

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U. S. Navy

U. S. Navy

John C. Smith

John C. Smith

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17527

CERTIFICATE OF DEATH

17519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS SANITARIUM</u>		d. STREET ADDRESS <u>920 F STREET N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>John F TAYLOR</u>		4. DATE OF DEATH <u>DEC 1 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. GAS Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WASH., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John E TAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE J MEALY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-07-7933</u>	
17. INFORMANT <u>John F. O'Connor</u>		Address <u>3503 N. 13th St., Arl. Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>probable acute coronary</u> DUE TO (c) <u>immediate</u>			INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 17</u> , 19 <u>66</u> , to <u>Dec 1</u> , 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>Oct 17</u> , 19 <u>66</u> , and that death occurred at <u>11:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Marvin Wadler</u>		22b. DATE SIGNED <u>12/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d. ADDRESS <u>8218 Wisc. Av. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>12/5/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Prince George, Md.</u>
24. FUNERAL DIRECTOR <u>Murphy Funeral Home</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. ADDRESS <u>3501 Columbia</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1524

1353

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 5-63

MEDICAL CERTIFICATION

MONTGOMERY COUNTY, MARYLAND											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17528						17520					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Life</u>						d. STREET ADDRESS <u>R1</u>					
3. NAME OF DECEASED (Type or print) <u>Sarah Ellen Taylor</u>						4. DATE OF DEATH <u>12 21 1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18, 1902</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacob Neal</u>		14. MOTHER'S MAIDEN NAME <u>Angelia Macabee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-32-2040</u>		17. INFORMANT <u>Phyllis Frazier, daughter</u>		Address <u>R1 Gaithersburg</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		3 yrs.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Chronic Glomerulonephritis</u> (b) <u>Diabetes Mellitus</u> (c) <u>Diabetes Mellitus</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus, Arteriosclerosis, Remote CVA</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1955</u> to <u>12-21, 1966</u> that (I) (we) last saw the deceased alive on <u>12-20-1966</u> , and that death occurred at <u>1A</u> M, from the causes and on the date stated above.		22a. SIGNATURE <u>Oliver B. Jackson</u> M.D.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>202 Martin Ln., Rockville Md.</u>		22e. REC'D BY REGISTRAR <u>DEC 27 1966</u>		22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22g. DATE SIGNED <u>12-21-66</u>		22h. SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/24/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove</u>		23d. LOCATION (City, town or county) (State) <u>Emory Grove Md.</u>		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		24b. ADDRESS <u>Rockville, Md.</u>		24c. REC'D BY REGISTRAR		24d. REGISTRAR'S SIGNATURE		24e. DATE SIGNED		24f. SIGNATURE	

17880

DEPARTMENT OF AGRICULTURE

17880

17880

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17529

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 7.9 Film G383 12/12/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17529

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47.3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>600 G St. NE</u>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Thomas</u> Last		4. DATE OF DEATH <u>See</u> Month <u>1</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> COMMON-LAW <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Married</u>	8. DATE OF BIRTH <u>9/28/20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u>	9. AGE (In years last birthday) <u>46</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Indiana Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>515-33-12551A</u>	
17. INFORMANT <u>Marie Johnson Washington</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>581.0</u> IMMEDIATE CAUSE (a) <u>Acute fatty metamorphosis, liver</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Bell</u> M.D.		22. DATE SIGNED <u>12/12/66</u>	
EXAMINER'S NAME (Type) _____		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/5/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>SAM BUTLER INC. FUNERAL HOME 3900 GA. AVE. N.W. WASHINGTON, D.C.</u>		25a. REC'D BY REGISTRAR <u>DEC 12 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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17530

CERTIFICATE OF DEATH

17521

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
c. LENGTH OF STAY IN 1b <u>1 yr. 6 mos.</u>		d. STREET ADDRESS <u>4333 Van Ness St N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Maude Lillian Thomas</u>		4. DATE OF DEATH <u>Dec. 21 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1875</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>2</u> Hours <u>1</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - U. S. Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>James Silcott</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ewers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-60-8376</u>	
17. INFORMANT <u>Daug.</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>154X</u> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>Carcinoma of rectum</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 4</u> , 1965, to <u>Dec 22</u> , 1966, that (I) (we) lost saw the deceased alive on <u>Dec 5</u> , 1966, and that death occurred at <u>4:25 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Malcolm D. Harrison</u>		22b. DATE SIGNED <u>Dec. 22, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Malcolm D. Harrison</u>		22d. ADDRESS <u>4535 Yuma St NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-23-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25. REC'D BY REGISTRAR <u>DEC 21 1966</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN lb <u>8 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Silver Spring Nursing Home</u>		d. STREET ADDRESS <u>2915-44th St., N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
NAME OF DECEASED (Type or print) <u>Caroline Cordes Thompson</u>		4. DATE OF DEATH <u>December 15</u> 19 <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7-1887</u> 85 yrs.
9. AGE (In years last birthday) <u>85</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Cordes</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Fieldman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unk</u>	
17. INFORMANT <u>Mrs. Caroline T. Semmons</u>		Address <u>2915-44th St Wash. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute cardio-respiratory failure</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis many years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>66</u> to <u>12/15</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>12/15</u> , 19 <u>66</u> , and that death occurred at <u>6:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William O. Bailey Jr.</u>		22b. DATE SIGNED <u>12/15/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William O. Bailey Jr., MD</u>		22d. ADDRESS <u>1835 Eye St, NW, Wash, DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>12-16-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cremation</u>		23d. LOCATION (City or Town) (County) (State) <u>Smithland Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gowler's Sons</u>		25a. RECEIVED BY REGISTRAR <u>5130 Wisc. Ave. NW</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 21 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF STATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17532					17524				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		a. STATE		b. COUNTY
Montgomery		Bethesda			13 Days		North Carolina		70-3
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
The Clinical Center, Bethesda 14, Maryland					Box #686				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
James Allen Thompson, Jr.					December 2 19 66				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11 November 1929		37 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Display Manager			---		North Carolina			USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
James Allen Thompson, Sr.					Lena V. Howard				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT				
No			241-38-0738		The Medical Records, The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u>									Unknown
190.9 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Disseminated malignant melanoma</u>									Unknown
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that we (this hospital) attended the deceased from <u>19 November, 19 66</u> , to <u>2 December, 1966</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2 December 19 66</u> , and that death occurred at <u>3:07M</u> , from the causes and on the date stated above.									
22a. SIGNATURE						A.M. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
<i>David F. Paulson MD</i>								2 December 1966	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			
David F. Paulson						National Institutes of Health, The Clinical Center, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial-transit 12-2-66		Fairview Mem. Park		Albermarle, North Car.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY, Bethesda, Maryland						DATE DEC 5 1966		<i>Charles Judge</i>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN Tb <u>15 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>501 Southwest Drive</u>		d. STREET ADDRESS <u>501 Southwest Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Edna W. Thurber</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1891</u>
9. AGE (In years last birthday) yrs. <u>75</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>15</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Agriculture</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cincinnati, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Wolf</u>		14. MOTHER'S MAIDEN NAME <u>Ada Hutton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Ignita Edry Thurber</u>		Address <u>501 Southwest Dr. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>527.1 CONGESTIVE HEART FAILURE (ACUTE)</u> DUE TO (b) <u>CHRONIC EMPHYSEMA</u> DUE TO (c) <u>10 YRS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1946</u> to <u>1 Dec. 1966</u> , that (I) (we) last saw the deceased alive on <u>11-24-1966</u> , and that death occurred at <u>22</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>L. B. Snow</u>		22b. DATE SIGNED <u>12/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. B. Snow</u>		22d. ADDRESS <u>7950 New Hampshire Ave., Langley Pk, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5 Dec. 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 5 1966</u>	

15233

INSTITUTE OF BEATH

15233

Name		Address		Occupation	
John Doe		123 Main St		Teacher	
Jane Smith		456 Oak Ave		Nurse	
Robert Johnson		789 Elm St		Engineer	
Mary White		101 Pine Rd		Homemaker	
David Brown		202 Cedar Ln		Student	
Susan Green		303 Birch Dr		Librarian	
Michael Black		404 Spruce St		Artist	
Emily Gold		505 Willow Ave		Writer	
Christopher Silver		606 Ash Rd		Lawyer	
Amanda Copper		707 Hickory Ln		Musician	
Daniel Iron		808 Walnut St		Scientist	
Olivia Tin		909 Chestnut Ave		Dancer	
Nathan Lead		1010 Maple Dr		Chef	
Sophia Zinc		1111 Poplar St		Designer	
Ethan Nickel		1212 Sycamore Ln		Athlete	
Isabella Platinum		1313 Magnolia Ave		Entrepreneur	
Alexander Silver		1414 Dogwood Rd		Historian	
Charlotte Gold		1515 Redwood St		Philosopher	
Benjamin Copper		1616 Cypress Ln		Inventor	
Victoria Iron		1717 Juniper Ave		Explorer	
William Tin		1818 Fir St		Explorer	
Grace Zinc		1919 Hemlock Dr		Explorer	
Henry Nickel		2020 Cedar St		Explorer	
Lillian Platinum		2121 Birch Ave		Explorer	
Robert Silver		2222 Spruce Rd		Explorer	
Elizabeth Gold		2323 Willow Ln		Explorer	
George Copper		2424 Ash St		Explorer	
Helen Iron		2525 Hickory Ave		Explorer	
Isaac Tin		2626 Walnut Rd		Explorer	
Julia Zinc		2727 Chestnut Ln		Explorer	
Karl Nickel		2828 Maple St		Explorer	
Lillian Platinum		2929 Poplar Ave		Explorer	
Michael Silver		3030 Sycamore Rd		Explorer	
Nancy Gold		3131 Dogwood Ln		Explorer	
Oscar Copper		3232 Redwood St		Explorer	
Pamela Iron		3333 Juniper Ave		Explorer	
Quinn Tin		3434 Fir Rd		Explorer	
Ruth Zinc		3535 Hemlock Ln		Explorer	
Samuel Nickel		3636 Cedar St		Explorer	
Tina Platinum		3737 Birch Ave		Explorer	
Ulysses Silver		3838 Spruce Rd		Explorer	
Vivian Gold		3939 Willow Ln		Explorer	
Walter Copper		4040 Ash St		Explorer	
Xavier Iron		4141 Hickory Ave		Explorer	
Yvonne Tin		4242 Walnut Rd		Explorer	
Zoe Zinc		4343 Chestnut Ln		Explorer	
Adam Nickel		4444 Maple St		Explorer	
Bella Platinum		4545 Poplar Ave		Explorer	
Caleb Silver		4646 Sycamore Rd		Explorer	
Diana Gold		4747 Dogwood Ln		Explorer	
Eli Copper		4848 Redwood St		Explorer	
Fiona Iron		4949 Juniper Ave		Explorer	
Gavin Tin		5050 Fir Rd		Explorer	
Hannah Zinc		5151 Hemlock Ln		Explorer	
Ian Nickel		5252 Cedar St		Explorer	
Jenna Platinum		5353 Birch Ave		Explorer	
Kai Silver		5454 Spruce Rd		Explorer	
Liam Gold		5555 Willow Ln		Explorer	
Mia Copper		5656 Ash St		Explorer	
Noah Iron		5757 Hickory Ave		Explorer	
Olivia Tin		5858 Walnut Rd		Explorer	
Percy Zinc		5959 Chestnut Ln		Explorer	
Quinn Nickel		6060 Maple St		Explorer	
Rachel Platinum		6161 Poplar Ave		Explorer	
Samuel Silver		6262 Sycamore Rd		Explorer	
Tina Gold		6363 Dogwood Ln		Explorer	
Ulysses Copper		6464 Redwood St		Explorer	
Victoria Iron		6565 Juniper Ave		Explorer	
Walter Tin		6666 Fir Rd		Explorer	
Xavier Zinc		6767 Hemlock Ln		Explorer	
Yvonne Nickel		6868 Cedar St		Explorer	
Zoe Platinum		6969 Birch Ave		Explorer	
Adam Silver		7070 Spruce Rd		Explorer	
Bella Gold		7171 Willow Ln		Explorer	
Caleb Copper		7272 Ash St		Explorer	
Diana Iron		7373 Hickory Ave		Explorer	
Eli Tin		7474 Walnut Rd		Explorer	
Fiona Zinc		7575 Chestnut Ln		Explorer	
Gavin Nickel		7676 Maple St		Explorer	
Hannah Platinum		7777 Poplar Ave		Explorer	
Ian Silver		7878 Sycamore Rd		Explorer	
Jenna Gold		7979 Dogwood Ln		Explorer	
Kai Copper		8080 Redwood St		Explorer	
Liam Iron		8181 Juniper Ave		Explorer	
Mia Tin		8282 Fir Rd		Explorer	
Noah Zinc		8383 Hemlock Ln		Explorer	
Olivia Nickel		8484 Cedar St		Explorer	
Percy Platinum		8585 Birch Ave		Explorer	
Quinn Silver		8686 Spruce Rd		Explorer	
Rachel Gold		8787 Willow Ln		Explorer	
Samuel Copper		8888 Ash St		Explorer	
Tina Iron		8989 Hickory Ave		Explorer	
Ulysses Tin		9090 Walnut Rd		Explorer	
Victoria Zinc		9191 Chestnut Ln		Explorer	
Walter Nickel		9292 Maple St		Explorer	
Xavier Platinum		9393 Poplar Ave		Explorer	
Yvonne Silver		9494 Sycamore Rd		Explorer	
Zoe Gold		9595 Dogwood Ln		Explorer	
Adam Copper		9696 Redwood St		Explorer	
Bella Iron		9797 Juniper Ave		Explorer	
Caleb Tin		9898 Fir Rd		Explorer	
Diana Zinc		9999 Hemlock Ln		Explorer	
Eli Nickel		10000 Cedar St		Explorer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17534						17526					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Colesville Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>87 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Colesville, Silver Spring</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>333 Bonifant Road</u>						d. STREET ADDRESS <u>333 BONIFANT Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Christopher</u> First <u>Joseph</u> Middle <u>Tolson</u> Last			4. DATE OF DEATH Month <u>Dec</u> Day <u>16</u> Year <u>1966</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 7, 1879</u>		9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmen</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Alfred Clifton Tolson</u>						14. MOTHER'S MAIDEN NAME <u>Catherine O'Hare</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-40-9074</u>		17. INFORMANT <u>Anna Tolson (wife)</u> Address <u>333 Bonifant Road Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>44</u> , to <u>Dec, 16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 16</u> , 19 <u>66</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>A. D. Bonifant</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u>						22d. ADDRESS <u>SANDY SPRING, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Dec 19, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>		
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>						25a. REC'D BY REGISTRAR <u>DEC 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

13536

13536

13536

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17535

17527

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 10 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda-Silver Spring Nursing Home		d. STREET ADDRESS 8700 Old Georgetown Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last NAOMI W. TOLSON		4. DATE OF DEATH Month Day Year Dec. 20, 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1889
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John T. Watson		14. MOTHER'S MAIDEN NAME Emily B. Wieland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-16-5964	
17. INFORMANT Son		Address Route 2, Greydon S. Tolson Dickerson, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO (b) Heart Congestive Heart Failure and pulmonary DUE TO (c) Metastatic Carcinoma of Breast		INTERVAL BETWEEN ONSET AND DEATH sev. days sev. weeks sev. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1963 to Dec 20, 1966 , that (I) (we) last saw the deceased alive on Dec 19, 1966 , and that death occurred at 10:30 P. M, from causes on and the date stated above.			
22a. SIGNATURE George H. Mitchell		22b. DATE SIGNED 12-21-66	
22c. PHYSICIAN'S NAME (Type) GEORGE H. MITCHELL		22d. ADDRESS 11125 Rockville Pike Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-23-66	23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 27 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

22271

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17536

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17528

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>12 hours</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>634 Northampton Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Alvie Edward Toms (Jr.)</u>		4. DATE OF DEATH <u>December 24, 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1942</u>
9. AGE (In years last birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Alvie</u>	
14. MOTHER'S MAIDEN NAME <u>Mollie L. Harne</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Navy-62-66</u>	
16. SOCIAL SECURITY NO. <u>220 42 5341</u>		17. INFORMANT <u>Hospital Records</u> Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe, comminuted, fractures of skull with intracranial hemorrhage & internal injuries.</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter number of injury in Part I or Part II or Part III, 18.) <u>Deceased on Rte. 495 attempted to pass car, hit rear, lost control & veered off.</u>		
20c. TIME OF INJURY Month, Day, Year <u>3:30 p.m. 12-23-66</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	20f. (City or town) <u>College Pk.</u> (County) <u>B. George, Md.</u> (State) <u>MD.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Deap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. DEAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <u>12/24/1966</u>		Address (street, city, town or county) <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 28, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Bethel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Nr. Wolfsville, Md.</u>
24. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 29 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

2000

052527

The above is a list of the
 names of the persons who
 have been admitted to the
 membership of the Society
 since the last meeting.

CERTIFICATE OF DEATH

17537

17529

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Edward Trammell		4. DATE OF DEATH Dec. 6 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-79
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Trammell		14. MOTHER'S MAIDEN NAME Lilly Alice Dove	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 412-30-8648	
17. INFORMANT Montgomery Gen. Hospital		Address Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 36 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASCVD & senility; emaciation;			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 28, 1966 to Dec. 6, 1966 , that (I) (we) last saw the deceased alive on Dec. 5, 1966 , and that death occurred at 2:05 PM , from causes and on the date stated above.			
22a. SIGNATURE Frederick Moomau M.D.		22b. DATE SIGNED 12-6-66	
22c. PHYSICIAN'S NAME (Type) Frederick Moomau, M.D.		22d. ADDRESS Medical Center, Sandy Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 8, 1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon	23d. LOCATION (City or Town) (County) (State) Nr. Damascus, Md.
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR DEC 8 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17331

RECORD OF DEATH

17331

RECORD OF DEATH

3 1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17538

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17539

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 408 Baltimore Road		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 408 Baltimore Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle Clara Last Twigg		4. DATE OF DEATH Month December Day 2 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 15 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Pa Paw, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Triplett		14. MOTHER'S MAIDEN NAME Emma Amick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT Mr. Wm. A. Twigg, Rockville, Md. Husband		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma 203X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/1/66 , to 12/2/66 , that (I) (we) last saw the deceased alive on 12/1/66 , and that death occurred at 8:34 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert C. Macon		22b. DATE SIGNED 12/2/66	
22c. PHYSICIAN'S NAME (Type) Robert C. Macon		22d. ADDRESS 809 Viers Mill Rd., Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 5, 1966	
23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 7 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

17539

CERTIFICATE OF DEATH

17531

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 3 Mos. 20 days Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda - Silver Spring Nursing Home		d. STREET ADDRESS 4521 Amherst Lane	
3. NAME OF DECEASED (Type or print) ERRETT Van Cleave		4. DATE OF DEATH Dec. 8 19 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) Sept 26, 1885 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joseph Van Cleave		14. MOTHER'S MAIDEN NAME Susan Bowers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Daughter Marjorie V.C. Lewis		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, terminal 444 X DUE TO Prostatism, chronic, and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Pyelonephritis, chronic and DUE TO Arteriosclerosis, severe, general		INTERVAL BETWEEN ONSET AND DEATH one month 1 yr + 5 yrs X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Hemiplegia rt, severe (July 1966) 2) Hypertension 3) Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1936 , to Dec 8 , 1966, that (I) (we) last saw the deceased alive on 12-20-1966 , and that death occurred at 10:20 AM , from causes and on the date stated above.			
22a. SIGNATURE Stewart Clapp M.D.		22b. DATE SIGNED 12-8-66	
22c. PHYSICIAN'S NAME (Type) Stewart Clapp		22d. ADDRESS 4740 Chevy Chase Dr. Chevy Chase 15 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-9-66	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 15 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

18281

0251

CERTIFICATE OF DEATH

17540

17533

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. HYATTSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>1606 ELSON ST.</u>	
3. NAME OF DECEASED (Type or print) <u>CLYDE W. VAN DYNE</u>		4. DATE OF DEATH Month <u>12</u> - Day <u>25</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/30/11</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bruce Van Dyne</u>		14. MOTHER'S MAIDEN NAME <u>---Bayes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Van Dyne</u> Address <u>same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct (left anteroseptal)</u> 420.1 DUE TO (b) <u>Coronary thrombosis (left anterior descending)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 9</u> , 19 <u>66</u> , to <u>Dec 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-25</u> 19 <u>66</u> , and that death occurred at <u>2:50 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>12-25-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d. ADDRESS <u>217 University Blde. Sd. Hy. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE THEREOF <u>12/25/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Powhatan Point Cemty.</u>	23d. LOCATION (City or Town) (County) (State) <u>Bellaire, Ohio</u>
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR <u>DATE 29 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17583

CERTIFICATE OF DEATH

17580

DECEASED (Last name)

DECEASED (First name)

DECEASED (Middle name)



17541

CERTIFICATE OF DEATH

17534

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>151</u>	
3. NAME OF DECEASED (Type or print) First <u>JACK</u> Middle <u>Dewar Villnave</u> Last <u></u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>12-29-15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispensary Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery Co. Liquor Control Board</u>	9. AGE (In years last birthday) <u>30</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Ottawa, Ontario, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harry S. Villnave</u>		14. MOTHER'S MAIDEN NAME <u>Alice Stewart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>112-05-4552</u>	
17. INFORMANT <u>Nina D. Villnave</u>		<u>4515 Mahan Road Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>NONE KNOWN</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 HOURS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>GOUT</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>10-16</u> , 19 <u>64</u> , to <u>12-5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-5</u> , 19 <u>66</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Michael Madeloff</u>		22b. DATE SIGNED <u>12-5-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MICHAEL MADELOFF</u>		22d. ADDRESS <u>10620 GEORGIA AVE SILVER SPRING, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 8, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	
23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>		23e. REC'D BY REGISTRAR <u>DEC 8 1966</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

15251

2000

CERTIFICATE OF DEATH

17542

17535

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
c. LENGTH OF STAY IN tb 14 days		d. STREET ADDRESS 6714 GUDE AVE.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. + HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NICHOLAS JAMES VOEHL		4. DATE OF DEATH Month Day Year 12 27 1966	
5. SEX M	6. COLOR OR RACE WH	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/22/77
9. AGE (In years lost birthday) yrs. 89		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST - U.S. Navy Yard		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Voehl		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO (b) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 1 week			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/13 , 19 66 , to 12/27 , 19 66 , that (I) (we) last saw the deceased alive on 26 DEC. 19 66 , and that death occurred at 9:10 A.M. from causes and on the date stated above.			
22a. SIGNATURE Morrill C. Quinnam, Jr.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Morrill C. Quinnam, Jr.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12/31/66	Cedar Hill Cemetery	Prince Georges Co. Md.
24. FUNERAL DIRECTOR The Allen Co. 2901 14th St. NW, D.C.		25. REC'D BY REGISTRAR DEC 30 1966	
25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE	

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82855

2010-07-10

• *Journal of Management Education* 24(1): 10-12

17543

CERTIFICATE OF DEATH

17532

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY in 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis Demetrios Voulelis</u>		4. DATE OF DEATH <u>12-6-1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/5/85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Demetrios Voulelis</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>579-48-9064</u>	
17. INFORMANT <u>Mary U. Breslin</u>		Address <u>246 East Avenue Mt. Carmel, Pennsylvania</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Acute pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Hypertension arteriosclerotic heart disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Lobular pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March, 1963</u> , to <u>Dec 6, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 6, 1966</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert B. Irey</u>		22b. DATE SIGNED <u>Dec 7, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>		22d. ADDRESS <u>7105 Riggs Rd Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 10, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>		24. FUNERAL DIRECTOR <u>C. Glen Carter</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>	
25a. REC'D BY REGISTRAR <u>DEC 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8271

1999

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17544

CERTIFICATE OF DEATH

17536

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 1 yr. 6 mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Congressional Manor Sanitarium		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY H. GUNTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NYATTSVILLE d. STREET ADDRESS 8346 ALLENDALE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUISE First Middle Last URELAND		4. DATE OF DEATH 1/3 30 Month Day Year 19 66	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-17-1896 9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME W. G. Deering		14. MOTHER'S MAIDEN NAME LINA Diehl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT FRANK S. URELAND Address 8346 ALLENDALE NYATTSVILLE, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO (b) Arteriosclerotic HD DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 2 hours year years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 8, 1965 to Dec. 30, 1966 that (I) (we) lost the deceased alive on Nov. 11, 1966 and that death occurred at 11:25 A.M. from causes and on the date stated above.			
22a. SIGNATURE G. Bowditch Hunter Jr. 22c. PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr.		22b. DATE SIGNED Dec. 30 1966 M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS 50 W. Edmonston, Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-31-1966	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem	23d. LOCATION (City or Town) (County) (State) BLADENSBURG MARYLAND
24. FUNERAL DIRECTOR W. W. Chambers Co., Riverdale, Md.		25a. REC'D BY REGISTRAR JAN 6 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15251

0253

17545

CERTIFICATE OF DEATH

17537

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>		d. STREET ADDRESS <u>205 DAVIS AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WALTER</u> First <u>N</u> Middle <u>WADDELL</u> Last				4. DATE OF DEATH Month <u>DEC</u> Day <u>16</u> Year <u>1966</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/1898</u>	9. AGE (In years lost-birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>..</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Waddell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-18-8449</u>		17. INFORMANT <u>Mary E. Waddell</u>		Address <u>as no 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>with metastases</u> DUE TO (c) <u>..</u>							INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Dec 2</u> , 19 <u>66</u> , to <u>Dec 16</u> , 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Dec 16</u> , 19 <u>66</u> , and that death occurred at <u>9:30</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>DeWitt E. DeLawter</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Dec 16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DeWITT E. DELAWTER</u>				22d. ADDRESS <u>8025 ABERDEEN RD Bethesda Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>12/19/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City or Town) (County) (State) <u>Gaithersburg Montg Md</u>	
24. FUNERAL DIRECTOR <u>Ernest C. Cartner</u>				ADDRESS <u>Gaithersburg</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 19 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17523

RECEIVED ON 12/11

17587

Continuation of previous
with the following

Principles

1. The first principle is that the
the second principle is that the
the third principle is that the
the fourth principle is that the
the fifth principle is that the
the sixth principle is that the
the seventh principle is that the
the eighth principle is that the
the ninth principle is that the
the tenth principle is that the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17546

Item 250 Film 5504 1/5/67 mh

CERTIFICATE OF DEATH

17538

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heathsville</u> 16.2	
c. LENGTH OF STAY in lb <u>2 Days</u>		d. STREET ADDRESS <u>1902 Beechwood Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>AGNES TAE WALKER</u>		4. DATE OF DEATH <u>December 22 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1881</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Cottin</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Hillson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> (c) <u>Arteriosclerosis, Generalized</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>2-3 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. _____	Month, Day, Year ____ 19 ____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 20</u> 19 <u>66</u> to <u>Dec 22</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 21</u> 19 <u>66</u> , and that death occurred at <u>9:27</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert B. Iray</u>		22b. DATE SIGNED <u>Dec 23, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IRAY</u>		22d. ADDRESS <u>7105 Riggs Rd Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 27 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Tringa Cemetery</u>		23d. LOCATION (City, town or county) <u>New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1966</u>	
ADDRESS <u>254 Carroll St Washington, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1889

1889

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH															
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
17547					CERTIFICATE OF DEATH					17539					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			c. LENGTH OF STAY IN 1b <u>1 1/2 days.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> <u>15.1</u>										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>					d. STREET ADDRESS <u>4970 BATTERY LANE</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>ALEXANDER M</u> Middle <u>WALKER</u> Last <u>WALKER</u>					4. DATE OF DEATH Month <u>DEC</u> Day <u>4</u> Year <u>19 66</u>										
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>8-26-97 69</u>			9. AGE (In years last birthday) yrs. <u>69</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Min. <u>66</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>66</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Economist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wilmington N.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>William A WALKER.</u>					14. MOTHER'S MAIDEN NAME <u>RIVENBARK ELLA.</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>1917</u>				16. SOCIAL SECURITY NO. <u>- -</u>		17. INFORMANT <u>Wife</u> Address <u>BATTERY LANE</u> <u>MARTHA B WALKER</u> <u>4970</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>② Bronchopneumonia undifferentiated</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Senescent metastasis</u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 mrs.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>9-20</u> , 19 <u>66</u> , to <u>12-3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-3</u> , 19 <u>66</u> , and that death occurred at <u>6:54</u> A.M., from causes and on the date stated above.															
22a. SIGNATURE: <u>Jw. Probsty 9/de Juyman</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-4-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Jos. W. Probsty JR. MD</u>					22d. ADDRESS <u>1234 19th NW Wash. D.C.</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-7-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem. Arlington, Va.</u>			23d. LOCATION (City or Town) (County) (State)								
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisconsin Ave. N.W. Wash. D.C.</u>					25a. REC'D BY REGISTRAR <u>DEC 8</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

17533

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FOR STATE
HEALTH DEPT.

17548

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17540

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo Heights</u>		c. LENGTH OF STAY IN 1b <u>16 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo Heights</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5115 Waukeshaw Rd.</u>				d. STREET ADDRESS <u>5115 Waukeshaw Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>LEE RICHARD Wallace</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>13</u> Year <u>1966</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1924</u>	9. AGE (In years lost birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sinclair Oil Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil</u>		11. BIRTHPLACE (State or foreign country) <u>Elburn, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Tripp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>577-34-7461</u>		17. INFORMANT Address <u>Erma Wallace, Wife, Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u>1:35</u> p.m. Month, Day, Year <u>Dec 13 1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home garage</u>	20f. (City or town) <u>Glen Echo</u>	(County) <u>Montgomery</u>	(State) <u>Md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>12/14/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/19/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City or Town) <u>Arlington, Va.</u>		(County) (State)	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Washington, D.C.</u>		ADDRESS <u> </u>		25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

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X

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17549

CERTIFICATE OF DEATH

17541

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12325 New Hampshire Ave., c. LENGTH OF STAY IN lb 11/22/66 to 12/26/66 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colonial Villa Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11605 Lockwood Dr., Silver Spr. d. STREET ADDRESS 11605 Lockwood Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Reuben Wallenrod		4. DATE OF DEATH Month Dec. Day 26 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) College Prof. & Writer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 67
11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Boris Wallenrod		14. MOTHER'S MAIDEN NAME Nechuma Paley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 068-28-7350	
17. INFORMANT Rae Wallenrod-Wife-As Above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Circulatory failure DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Perihematomas			INTERVAL BETWEEN ONSET AND DEATH 8 days 5 1/2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 12, 1966 , to Dec 26, 1966 , that (I) (we) last saw the deceased alive on Dec 22, 1966 , and that death occurred at 3:33 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Arthur S. Bressler		22b. DATE SIGNED 12-26-66	
22c. PHYSICIAN'S NAME (Type) Arthur S. Bressler, MD		22d. ADDRESS 10881 Lockwood Dr S.S. Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF DEC 28, 1966	23c. NAME OF CEMETERY OR CREMATORY CEDAR PARK CEMETERY	23d. LOCATION (City or Town) (County) (State) PARANIS N. J.
24. FUNERAL DIRECTOR BERNARD PANLAKKY-SONS		25a. REC'D BY REGISTRAR WASH. DC 3501-1451 N.W.	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12521

RECEIVED BY DEPT.

12521



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17550

CERTIFICATE OF DEATH

17542

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner 12-28-66 11:30 AM

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>16.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Sam. Hospital</u>		d. STREET ADDRESS <u>6646-24th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Rebecca</u> Last <u>Walsh</u>		4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Prof.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mont Co. Md</u>	
13. FATHER'S NAME <u>Thomas W. Ward</u>		14. MOTHER'S MAIDEN NAME <u>Jane R. Crammell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(Bro) Dr. Thomas Ward</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>24yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 1964, to <u>12-28</u> , 1966, that (I) (we) last saw the deceased alive on <u>Sept 1</u> , 1966, and that death occurred at <u>11:05 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert B. Irey</u>		22b. DATE SIGNED <u>12-28-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>		22d. ADDRESS <u>7105 Riggs Rd Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>12/31/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR, ADDRESS <u>S.H. Hines Co. Wash D.C.</u>		25a. REC'D BY REGISTRAR <u>JAN 4 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

11551

RECEIVED BY THE DIRECTOR

11551

RECEIVED BY THE DIRECTOR

RECEIVED BY THE DIRECTOR

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17551

17543

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 1hr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. STREET ADDRESS 12117 Selfridge Road	
3. NAME OF DECEASED (Type or print) First William Middle NMI Last Walter		4. DATE OF DEATH Month 12 Day 6 Year 19 66	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/16/08
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursery Salesman		10b. KIND OF BUSINESS OR INDUSTRY Mr. Landscaper	
11. BIRTHPLACE (State or foreign country) Pittsburgh, Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Walter		14. MOTHER'S MAIDEN NAME Louisa Hildahofer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 190-09-8061	
17. INFORMANT Wife Walter		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Artery Heart Disease (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Keap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. KEAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED Dec. 6, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 9, 1966	
23c. NAME OF CEMETERY OR CREMATORY Woodrow Cemetery		23d. LOCATION (City or Town) (County) (State) Huntington, West Virginia	
24. FUNERAL DIRECTOR John B. Thomas Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR DEC 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

17543

17543

17543

Montgomery

Maryland

Montgomery

Silver Spring

Silver Spring

Holy Cross Hospital

12117 Belknap Road

William

Walter

12

X

25

25

Male

Nursery Salesman

Elizabeth, Penna

USA

Pierson

Wife Walter

Same as

Great Northern Life Insurance Co

X X

1200 - 1200 - 1200

17552

CERTIFICATE OF DEATH

17544

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>17 days</u>		d. STREET ADDRESS <u>7115 Sycamore Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hattie Maud Walters</u>		4. DATE OF DEATH Month <u>December</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-20-80</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Martin</u>		14. MOTHER'S MAIDEN NAME <u>? Paulson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>4-200</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 25, 1966</u> to <u>Dec 12, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 11, 1966</u> , and that death occurred at <u>6:53 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Benne G. Bandler</u>		22b. DATE SIGNED <u>12-12-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>BENNE G. BENDLER M.D.</u>		22d. ADDRESS <u>10820 Georgia Ave Wheaton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>cremation</u>	<u>Dec 14 1966</u>	<u>2001 Lincoln Crematory</u>	<u>Colmar Manor Pk. Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>Walter Walters Washington, D.C. 20012</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 16 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12544

CENTRIFUGAL DE GRANT

12552

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "centrifugal" and "grant" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17553

CERTIFICATE OF DEATH

17545

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>53 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington S.E.</u>		47.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>1727 28th St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LOZELLE INEZ WALTERS</u>		4. DATE OF DEATH <u>December 1, 1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>May 4, 1904</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.S.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Flanigan</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Lee Hensley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>502.0</u> DUE TO <u>Chronic Bronchitis and Pulmonary Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Associated with Cor Pulmonale</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adrenal adenomas</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-7</u> , 19 <u>66</u> , to <u>12-1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-30</u> , 19 <u>66</u> , and that death occurred at <u>2:45</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>12-1-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.W. DANISH</u>		22d. ADDRESS <u>1106 Spring St. S.E. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-5-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George County Md</u>	
24. FUNERAL DIRECTOR <u>Robert A. Mattingly</u>		ADDRESS <u>131 11th Street S.E. D.C.</u>	
25a. REC'D BY REGISTRAR <u>DEC 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

4251

REST

17554

CERTIFICATE OF DEATH

17546

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner - Dr. B. B. B. 12/20/66 gga

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 1hr		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital						d. STREET ADDRESS 4230 Roundhill Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Glenna Edith Ward		4. DATE OF DEATH Month Day Year 12 20 66		5. SEX Fe		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-21-11		9. AGE (In years last birthday) 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafateria Worker		10b. KIND OF BUSINESS OR INDUSTRY Bd of Ed		11. BIRTHPLACE (County & State, or foreign country) Sparks, W Va		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Louis Elkins		14. MOTHER'S MAIDEN NAME Samantha Kearns			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Lenis Ward-husband		Address Same as # 2							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure due to:												INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) Arteriosclerotic heart disease manifest by													
DUE TO (c) left ventricular aneurysm myocardial infarction, old coronary occlusion, old													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan 10 , 19 65 , to Dec 20 , 19 66 that (I) (we) last saw the deceased alive on Nov 28 , 19 66 , and that death occurred at 1:55 PM , from causes and on the date stated above.													
22a. SIGNATURE John J. Curry				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/20/66					
22c. PHYSICIAN'S NAME (Type) John J. Curry, M.D.				22d. ADDRESS 16650 Georgia Ave Silver Spring Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 24, 1966		23c. NAME OF CEMETERY OR CREMATORY Fulks Cemetery		23d. LOCATION (City or Town) (County) (State) Lincoln County, W. Virginia							
24. FUNERAL DIRECTOR John B. Thomas Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE DEC 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

34271

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17555

CERTIFICATE OF DEATH

17547

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLARKSBURG</u> 15.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>RT Box 114</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Addie ELIZABETH WATKINS</u>		4. DATE OF DEATH Month Day Year <u>Dec 26 19 66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 18-1887</u> 79
9. AGE (In years last birthday) yrs. <u>79</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM owner.</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>HOWARD Co. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>SAMUEL Lewis SHIPLEY</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH GRIMES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-36-4250</u>	
17. INFORMANT Address <u>ORA H King RTI Box 114</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>442X</u> IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Advanced Arteriosclerotic Cardio-Vascular-Renal Disease with hypertension.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>--</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>--</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>July 10, 1964</u>	20f. (City or town) (County) (State) <u>December 26, 1966</u>
21. I certify that (I) (the hospital) attended the deceased from <u>July 10, 1964</u> to <u>December 26, 1966</u> , that (I) (we) lost saw the deceased alive on <u>December 22, 1966</u> , and that death occurred at <u>4:20 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>M. McKendree Boyer, M.D.</u>		22b. DATE SIGNED <u>DEC 29 1966</u>	22c. PHYSICIAN'S NAME (Type) <u>M. McKendree Boyer, M.D.</u>
22d. ADDRESS <u>9701 Church Street, Damascus, Maryland.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 28, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Meth.</u>	23d. LOCATION (City or Town) (County) (State) <u>Browningsville, Md.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Olin L. Molesworth, Damascus, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 29 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5268

222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17556
17548
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 46 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS 5 Alice Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Beatrice Elizabeth Watkins				4. DATE OF DEATH Month Day Year December 9 19 66									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 July 1922		9. AGE (in years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas M. Steep						14. MOTHER'S MAIDEN NAME Florence Smith							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 577-20-4762		17. INFORMANT The Medical Records, The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal failure DUE TO (c) Metastatic Carcinoma of breast & liver										INTERVAL BETWEEN ONSET AND DEATH 24 Hours Days 1 Year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (X) (this hospital) attended the deceased from 24 October , 19 66 , to 9 December 19 66 , that (we) last saw the deceased alive on 9 December 19 66 , and that death occurred at 9:00 from the causes and on the date stated above.													
22a. SIGNATURE Paul Daniel Berk						ATTENDING PHYS. <input type="checkbox"/> M.O. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> P.M. 12/10/66		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Paul D. Berk, MD,						22d. ADDRESS National Institutes of Health, The Clinical Center, Bethesda 14, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Dec. 13, 1966		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges County, Maryland					
24. FUNERAL DIRECTOR Harry H. Witzke, 321 Columbia Pike, Ellicott City, Md.						25a. REC'D BY REGISTRAR DEC 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

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17557

CERTIFICATE OF DEATH

17549

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CONGRESSIONAL MANOR SAN.</u>		d. STREET ADDRESS <u>3718 JENNIFER ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>JANIE</u> Middle <u>R.</u> Last <u>WEAVER</u>		4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/18/1884</u> 32 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY H. ROSSON</u>		14. MOTHER'S MAIDEN NAME <u>C. A. HARLOW</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>- -</u>	
17. INFORMANT <u>MRS. ALICE W. SMITH</u> Address <u>8809-2nd Ave. S.S. Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>204.0</u> IMMEDIATE CAUSE (a) <u>Lymphatic Leukemia</u> DUE TO (b) <u>chronic.</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1 Jan, 1966</u> to <u>29 DEC 1966</u> that (I) (we) lost saw the deceased alive on <u>28 DEC 1966</u> , and that death occurred at <u>1230</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>M.H. Richwine</u>		22b. DATE SIGNED <u>29 DEC. 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.H. RICHWINE, MD.</u>		22d. ADDRESS <u>5522 WESTERN AVE - CHEVY CHASE, 15, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>12-31-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Robinson River Primitive/Brightwood, Va.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15251

1505

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
17558					17550									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY <u>Montgomery</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairway Hills</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairway Hills</u>									
c. LENGTH OF STAY IN 1b <u>18 years</u>					d. STREET ADDRESS <u>6006 Benalder Dr.</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6006 Benalder Drive</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Oliver Smith Weaver</u>					4. DATE OF DEATH <u>12 30 1966</u>									
5. SEX <u>M.</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>10/9/1891</u> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator-Trolley</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Maryland</u>				
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>					13. FATHER'S NAME <u>Thomas Andrew Weaver</u>					14. MOTHER'S MAIDEN NAME <u>Alice Ann Evans</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes.</u> (If yes give war or dates of service) <u>WW I</u>					16. SOCIAL SECURITY NO. <u>578-10-5374</u>					17. INFORMANT <u>WIFE</u> Address <u>6006 Benalder Dr. Fairway Hills, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable pneumonia RLL</u> 334X DUE TO (b) <u>Debilitation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cerebrovascular Disease</u> DUE TO (c) <u>Arthritis - Rheumatoid</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis - Rheumatoid</u>										INTERVAL BETWEEN ONSET AND DEATH <u>24-48 hrs.</u> <u>3 months</u> <u>Unknown</u>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year <u>Hour a.m. p.m.</u> <u>19</u>										20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)				
21. I certify that (1) this hospital attended the deceased from <u>12/29/1966</u> to <u>12/30/1966</u> , that (1) <u>two</u> last saw the deceased alive on <u>12/29/1966</u> , and that death occurred at <u>1150A</u> M, from the causes and on the date stated above.										22a. SIGNATURE <u>Earle B. Thompson MD</u> 22b. DATE SIGNED <u>12/30/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Earle B. Thompson MD</u>										22d. ADDRESS <u>2121 Pa Av NW Wash DC</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										23b. DATE THEREOF <u>1-4-67</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>										23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>				
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>										25a. REC'D BY REGISTRAR <u>JAN 5 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>				

13550

13558

GOOD MENAGERIE DRIVE

GOOD MENAGERIE DRIVE

ROBERT A. LUTHERY, Defendant, New York
1-1-57
LUTHERY, Defendant, New York

17559

CERTIFICATE OF DEATH

17551

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN lb 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights 16.2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 108 Comanche Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Herman WEBER				4. DATE OF DEATH Month Day Year December 21 19 66			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 13, 1931		9. AGE (In years last birthday) yrs. 35	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Evansville, Ind.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Michael Weber				14. MOTHER'S MAIDEN NAME Myrtle Ruth Humphrey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO.		17. INFORMANT Forest Heights Md. Mrs. Mercedes Weber, 108 Comanche Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 20X3 IMMEDIATE CAUSE (a) Acute Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from Dec. 7 , 19 66 , to Dec. 21 , 19 66 , that it (we) last saw the deceased alive on Dec. 21 , 19 66 , and that death occurred at 0910 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>David R. Foreman</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec. 21, 1966	
22c. PHYSICIAN'S NAME (Type) David R. Foreman, M.D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 23-66		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Simmons Brothers 1661 Good Hope Road, S. E. Washington, D.C.				25a. REC'D BY REGISTRAR DATE DEC 23 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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David H. Johnson

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

FOR STATE HEALTH DEPT.

17560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17552

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY (In days) <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San. & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15.1 d. STREET ADDRESS <u>18 Manchester Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George Alexander Harmon West</u> First <u>Harmon</u> Middle <u>Alexander</u> Last <u>West</u>				4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1966</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-22-1902</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Harvey West</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Daughter - Mrs Janet Dryman</u> Address <u>18 Manchester Place, S. S., Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute bilateral bronchopneumonia</u> DUE TO (b) <u>Severe pulmonary emphysema</u> DUE TO (c) <u>527.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>12/22/1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 27, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15560

X

X

X

X

13/33/1964

13/33/1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17561						17553					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>3446</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Westwood Nursing Home</u>						d. STREET ADDRESS <u>2445 15th Street</u>					
3. NAME OF DECEASED (Type or print) <u>Mr. Anita J. White</u>						4. DATE OF DEATH <u>12 9 1966</u>					
5. SEX <u>7</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-9-1886</u>		9. AGE (In years last birthday) <u>30</u> yrs.		10. IF UNDER 1 YEAR <u>7</u> Months <u>7</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Modern net employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Internal Revenue</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Jackson Co, Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John James</u>						14. MOTHER'S MAIDEN NAME <u>Jane Jenkins</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>579-60-8427</u>		17. INFORMANT <u>John F. Miller-3056 Chestnut St. NW</u> Address <u>Washington D</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>											
DUE TO (b) <u>Coronary Arteriosclerosis heart disease</u>											
DUE TO (c) <u>3 years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, essential</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>a.m.</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>15 SEPT, 1966</u> to <u>9 DEC, 1966</u> , that (I) (we) last saw the deceased alive on <u>9 DEC, 1966</u> , and that death occurred at <u>4:54 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Joseph J. Wallace</u>						22b. DATE SIGNED <u>9 DEC 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>Joseph J. Wallace</u>						22d. ADDRESS <u>1830 K. Street N. W.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12/12/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>			
24. FUNERAL DIRECTOR <u>The H. Hines Co. 2901 14th St. NW.</u>						25a. REC'D BY REGISTRAR <u>DEC 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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12571

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Investigation

25

Arthur

Wheat of Norway

more quiet

Stable

7

Elle est née à Paris le 10 mai 1844.

7-1-0-052

The H. House Co. 2001 W. 2nd St. Minn.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17562

CERTIFICATE OF DEATH

17554

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>4523 DABNEY DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>A.</u> Last <u>WHITTINGTON</u>		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-13</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. D.C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES P. WHITTINGTON</u>		14. MOTHER'S MAIDEN NAME <u>MARY KELLY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-09-3322</u>	
17. INFORMANT <u>Mrs. MARY S. WHITTINGTON</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute</u> DUE TO (b) <u>Coronary artery disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u>60</u> , to <u>10/24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 23</u> 19 <u>66</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Ernest E. Cornelison</u>		22b. DATE SIGNED <u>12/24/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ERNEST E. CORNELISON MD</u>		22d. ADDRESS <u>5703 MARLBORO PIKE. SE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-28-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>SUITLAND MARYLAND</u>
24. FUNERAL DIRECTOR <u>Francis J. Bellini's 3821-44th St. NW, Wash. D.C.</u>		25. REC'D BY REGISTRAR <u>DEC 28 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17554

UNITED STATES OF AMERICA

17554



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17563

CERTIFICATE OF DEATH

17555

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Virginia b. COUNTY Norfolk	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 7718 Enfield Street	
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last WIBLE		4. DATE OF DEATH Month December Day 18 Year 19 66	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1966
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Portsmouth, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Kenneth Wible		14. MOTHER'S MAIDEN NAME Esperanza Gomez	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Norfolk		Address Virginia LCDR William K. Wible, 7718 Enfield St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypoplasia of the left ventricular, patent ductus arteriosus DUE TO (b) 7541 DUE TO (c) ductus arteriosus			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (x) (this hospital) attended the deceased from Dec. 17 , 19 66 , to Dec. 18 , 19 66 that (x) (we) last saw the deceased alive on Dec. 18 , 19 66 , and that death occurred at 120PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Jerry J. Tomasovic</i>		22b. DATE SIGNED Dec. 20, 1966	
22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-21-66	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home		25a. REC'D BY REGISTRAR DATE DEC 23 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13552

DEPARTMENT OF HEALTH

13553

Virginia

Montgomery

W. L. R. R.

2 days

Person (W. L. R. R.)

1000 E. 10th Street

1000 E. 10th Street

December 10

W. L. R. R.

2 days

2 days

W. L. R. R.

W. L. R. R.

USA

1000 E. 10th Street

W. L. R. R.

1000 E. 10th Street

1000 E. 10th Street

1000 E. 10th Street

W. L. R. R.

W. L. R. R.

1000 E. 10th Street

1000 E. 10th Street

1000 E. 10th Street

1000 E. 10th Street

1000 E. 10th Street

1000 E. 10th Street

17564

CERTIFICATE OF DEATH

17556

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i> c. LENGTH OF STAY IN 1b <i>15.1</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Randolph Hills Nursing Home</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> d. STREET ADDRESS <i>110 Lucas Lane</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>John Scott Wiley</i>		4. DATE OF DEATH Month Day Year <i>12 12 1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 18, 1894</i>
9. AGE (In years lost birthday) <i>72 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired -</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry G. Wiley</i>		14. MOTHER'S MAIDEN NAME <i>Laura Christenson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes WWI</i>		16. SOCIAL SECURITY NO. <i>105-16-8927</i>	
17. INFORMANT <i>Mrs. Lelia G. Wiley - See Item 2.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Thrombosis</i> 332X DUE TO (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) <i>Pulmonary Emphysema</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>36 hours</i> <i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pulmonary Emphysema</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>November 10, 1966</i> to <i>12/13/1966</i> , that (I) (we) last saw the deceased alive on <i>12/11/1966</i> , and that death occurred at <i>10:54 A.M.</i> from causes on the date stated above.			
22a. SIGNATURE <i>Robert C. Macon</i>		22b. DATE SIGNED <i>12/12/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert C. Macon</i>		22d. ADDRESS <i>809 Viero Mill Rd. Rockville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>12-13-1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Md.</i>	
24. FUNERAL DIRECTOR <i>Joseph Cawler's Sons, Inc.</i> <i>5130 Wisc. Ave. N.W. Wash. DC.</i>		25a. REC'D BY REGISTRAR <i>DEC 19 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

13556

CLASSIFICATION OF DEATH

13556

1. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the Department of Health, State of New York, for the year 1910.

2. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the Department of Health, State of New York, for the year 1910.

3. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the Department of Health, State of New York, for the year 1910.

4. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the Department of Health, State of New York, for the year 1910.

5. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the Department of Health, State of New York, for the year 1910.

6. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the Department of Health, State of New York, for the year 1910.

7. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the Department of Health, State of New York, for the year 1910.

8. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the Department of Health, State of New York, for the year 1910.

9. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the Department of Health, State of New York, for the year 1910.

10. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the Department of Health, State of New York, for the year 1910.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

B.P.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 11 MARYLAND											
17565 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> <u>151</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3926 Kincaid Terrace</u>					d. STREET ADDRESS <u>10411 Fawcett Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>U. H.</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>December</u> Day <u>5</u> Year <u>19 66</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>May 6, 1889</u>		9. AGE (In years last birthday) <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Clerk-Auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Homer VanHyning</u>		14. MOTHER'S MAIDEN NAME <u>Ella Stauffer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. June W. Herman</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> (c) <u>Severely</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>NO</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>yrs.</u> <u>yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 1, 1966</u> to <u>12/5/66</u> , that (I) (we) last saw the deceased alive on <u>12/4/66</u> , and that death occurred at <u>3A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Sam Allen, M.D.</u>		22b. DATE SIGNED <u>12/5/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Sam Allen, M. D.</u>		22d. ADDRESS <u>Kensington, Md.</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 7, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 8 1966</u>			
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u>		25d. DATE <u>DEC 8 1966</u>		25e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

17563

10/10/1941
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10/10/1941

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17566

17558

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>P. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6506 Knollbrook Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Worric Beecher Williams</u>		4. DATE OF DEATH <u>12-8-66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - U.S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>William Williams</u>		14. MOTHER'S MAIDEN NAME <u>Sigourney Fleischee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>220-05-7495</u>	
17. INFORMANT <u>Virginia - Wife - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive infarction, left cerebellum</u> DUE TO (b) <u>Thrombosis, left cerebellar artery</u> DUE TO (c) <u>Cerebral arteriosclerosis and hypertensive heart disease.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/19</u> , 19 <u>66</u> , to <u>11/8</u> , 19 <u>66</u> , that (I) <u>we</u> last saw the deceased alive on <u>11/8</u> , 19 <u>66</u> , and that death occurred at <u>12:30</u> PM, from causes on and on the date stated above.			
22a. SIGNATURE <u>Thomas Tolamer</u> M.D.		22b. DATE SIGNED <u>12/18/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>8218 Wisconsin Ave, Bethesda, Md</u>		22d. ADDRESS	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 13, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Arthur Waters Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>DEC 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17567 CERTIFICATE OF DEATH 17559

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>112 Lee Avenue</u>		d. STREET ADDRESS <u>112 Lee Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Edgar</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 10, 1915</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>music</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar Lee Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Edna Lee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>484-10-4241</u>	
17. INFORMANT <u>Mrs. Lois R. Wilson (same as #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>356.1 Congestive heart failure</u> DUE TO (b) <u>Extensive Amyotrophic lateral sclerosis</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , 19 <u>62</u> , to <u>15 Dec</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>15 Dec</u> , 19 <u>66</u> , and that death occurred at <u>11 P.</u> M., from the causes and on the date stated above.		22b. DATE SIGNED <u>15 Dec 66</u>	
22a. SIGNATURE <u>Ernest K. Harmon</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <u>Ernest K. Harmon MD</u>	
22d. ADDRESS <u>9301 Colesville Rd S.W.</u>		22e. REC'D BY REGISTRAR	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 19, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington DC</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Walters</u> ADDRESS <u>257 Carroll A.W. Ave</u>		25a. REC'D BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>DEC 19 1966</u>	

1358

1358

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FOR STATE
HEALTH DEPT.

17568

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17560

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>83.3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmersville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Coleville Rd. at D.O. RR.</u>		d. STREET ADDRESS <u>Rt. 1</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES HALL WILSON SR</u>		4. DATE OF DEATH Month <u>12</u> - Day <u>23</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-08-08</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>58</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Farmville, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wm A. Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Holman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Catherine M. Wilson</u>		Address <u>Adelphi Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple extreme injuries</u> DUE TO (b) <u>due to being struck by a train</u> DUE TO (c) <u>due to being struck by a train</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased walking on RR tracks and struck by a train</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:00</u> p.m. <u>12-23</u> 19 <u>66</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street (RR Track)</u>	20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/27/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Coleman Manor Pro La Md</u>	
24. FUNERAL DIRECTOR <u>F. Esch's sons Hyattsville, Md</u>		25. REC'D BY REGISTRAR <u>DEC 29 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22. DATE SIGNED <u>12/23/1966</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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17500

James M. Hall
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11/20/1961
11/20/1961
11/20/1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17569

CERTIFICATE OF DEATH

17561

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>4/21/65</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>		d. STREET ADDRESS <u>10205 Drumm Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E</u> Last <u>Wingfield</u>		4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/4/1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>76</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chas Butler</u>		14. MOTHER'S MAIDEN NAME <u>Nora Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>KENNETH BELL</u> Address <u>YOUNGWOOD, PA.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>nephrosclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>15 yrs. last</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anemia, cause undetermined</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9 Apr. 1964</u> to <u>Dec. 9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 7</u> , 19 <u>66</u> , and that death occurred at <u>2:15 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Philip H. Varner</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>PHILIP H. VARNER</u>		22d. ADDRESS <u>Wheaton Maryland 10620 GA. AVE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12 DEC 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>YOUNGWOOD CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>YOUNGWOOD, PENN'A.</u>
24. FUNERAL DIRECTOR <u>W. W. Chambers C</u>		ADDRESS <u>Beverdale mol</u>	25a. REC'D BY REGISTRAR DATE <u>DEC 12 1966</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

17561

CERTIFICATE OF DEATH

17560

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR ATSMC
5M 1/62

17570

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17562

Items 18 & 21, Film G387 3/21/67 cag

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Derwood</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery Gen. Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u> d. STREET ADDRESS <u>Derwood Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROBERT EARL Woods</u> First Middle Last		4. DATE OF DEATH <u>Dec. 16, 1966</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-1920</u> yrs. last birthday
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Government</u>	11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>
13. FATHER'S NAME <u>Richard I Woods</u>		14. MOTHER'S MAIDEN NAME <u>Myrtle L. Winters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Virginia R. Woods</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Peritonitis due to</u> 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforated Peptic Ulcer</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		17. INFORMANT Address <u>Same as # 2</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Derwood, Md.</u> DATE SIGNED <u>Dec. 16, 1966</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 18 1966</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>	22d. LOCATION (City, town, or country) (State) <u>Laytonsville Md.</u>
23. FUNERAL DIRECTOR <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>DEC 21 1966</u>	

MEDICAL CERTIFICATION

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Francis H. Barber
Daytonsville, Mo.
Burial Dec. 15 1906 Daytonsville

Daytonsville Mo.

Barber R. K. Barber
Dec. 15 1906
X X X

No
Virginia R. Woods
Same as 2
Lyle L. Winters

Richard I. Woods

Robert
City Government Tenn. U.S.A.

3-26-1906

Woods

Robert

X

Woods

D.A.

Woods

Woods

Woods

Woods

Dec. 15 1906

1906

1906

(M)

17571

CERTIFICATE OF DEATH

17563

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)			c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 2436 North Glebe Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Percy Middle Talmadge Last WRIGHT				4. DATE OF DEATH Month December Day 13 Year 1966			
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 18, 1885	
9. AGE (In years last birthday) 81 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy (Retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Huntingdon, Penn.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Thomas J. Wright			
14. MOTHER'S MAIDEN NAME Jeanette Bell Steel				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW I			
16. SOCIAL SECURITY NO. 577-52-3612				17. INFORMANT Arlington Address Va. Mrs. Florence Wright, 2436 North Glebe Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia/ Arteriosclerotic cardio- DUE TO vascular disease, advanced and severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atelectasis, focal, right lower lobe; Fracture, simple, left ribs, #7 through #11.							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 24, 1966 to Dec. 13, 1966 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 13, 1966 , and that death occurred at 955P M, from causes and on the date stated above.					
22a. SIGNATURE <i>E. Perlman</i> M.D.				22b. DATE SIGNED Dec. 15, 1966		22c. PHYSICIAN'S NAME (Type) E. PERLIN, M. D.	
22d. ADDRESS Naval Hospital, Bethesda, Md.				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF Dec. 19, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Va.			
24. FUNERAL DIRECTOR Ives Funeral Home				25a. REC'D BY REGISTRAR DEC 19 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
2847 Wilson Blvd. Arlington, Va.							

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(PART) 06-00000

Case.

U. S. 2. 10-11-57

Handwritten: 1890, 1891, 1892, 1893, 1894, 1895, 1896, 1897, 1898, 1899, 1900, 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571

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• 4 • JUL 1982 • 28

• 07 • 1074174

CERTIFICATE OF DEATH

17572

17564

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 47.3		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY 47.3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM HOSP		d. STREET ADDRESS 2617 31st Place NE D.C.	
3. NAME OF DECEASED (Type or print) MRS. LENA M. YOBST		4. DATE OF DEATH Month 12 Day 11 Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 11, 1888
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 12 Days 11 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NSF.		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? AMER.	
13. FATHER'S NAME GOTTLIEB NESS		14. MOTHER'S MAIDEN NAME FREDERICKA WERTIG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT OT CHAAT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION WITH SHOCK DUE TO (b) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CORONARY ARTERY ATHEROSCLEROTIC HEART DISEASE			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 1959, to Dec 11 , 1966, that (I) (we) last saw the deceased alive on Dec 11 , 1966, and that death occurred at 9:38 PM , from causes and on the date stated above.			
22a. SIGNATURE Robert B. Irey		22b. DATE SIGNED Dec 11, 1966	
22c. PHYSICIAN'S NAME (Type) ROBERT B. IREY		22d. ADDRESS 17105 Riger Rd Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12.15.66	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Maryland
24. FUNERAL DIRECTOR LEE FUNERAL HOME		25a. REC'D BY REGISTRAR DEC 14 1966	
ADDRESS 300 F ST. N.E.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15501

RECEIVED

15501

15501

Handwritten notes and signatures, mostly illegible due to fading and bleed-through. Some legible fragments include "RECEIVED", "15501", and "15501".

17573

CERTIFICATE OF DEATH

17565

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>17 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15.1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>8505 Springvale Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lu</u> Middle <u>may</u> Last <u>Young</u>				4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-10-83</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Johnstown, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frank B. Good</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Ann Mangls</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Leventry</u> <u>Mrs. John U. Leventry</u> <u>3104 Cordova St. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>584X</u> <u>HEPATIC FAILURE</u> DUE TO (b) <u>Biliary Cirrhosis</u> DUE TO (c) <u>Cholelithiasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>Dr</u> (this hospital) attended the deceased from <u>12-23</u> , 19 <u>66</u> to <u>12-24</u> , 19 <u>66</u> that <u>we</u> (we) last saw the deceased alive on <u>12-24</u> , 19 <u>66</u> , and that death occurred at <u>12:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Morris Perry</u>				22b. DATE SIGNED <u>12-24-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Morris Perry</u>	
22d. ADDRESS <u>11602 Georgia Ave., S. S., Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 28, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Johnstown, Pennsylvania</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>8434 Georgia Ave.</u> <u>Warner E. Humphrey, Inc.</u> <u>Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 30 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Clear of med examiner

17523

CERTIFICATE OF DEATH

17523

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Cause of Death		Place of Death	
Occupation		Residence	
Marital Status		Date of Marriage	
Signature of Physician		Signature of Registrar	
Date of Issuance		Place of Issuance	

17574

CERTIFICATE OF DEATH

17566

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN b. <u>1 Hour</u>				d. STREET ADDRESS <u>4901 Rugby Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Helen</u>		First <u>First</u> Middle <u>Zywith</u> Last <u>Last</u>		4. DATE OF DEATH <u>12-3</u>		Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-14</u>		9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Sebell</u>				14. MOTHER'S MAIDEN NAME <u>Anna Kalart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>163-22-8116</u>		17. INFORMANT <u>Husband - Stanley Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Hemorrhage, massive, pelvis</u> <u>181.0</u> DUE TO (b) <u>Carcinoma, urinary bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/3/66</u> to <u>12/3/66</u> , that (I) (we) last saw the deceased alive on <u>12/3/66</u> , and that death occurred at <u>11</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Timothy J. Tehan</u> M.D.				22b. DATE SIGNED <u>12/4/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Timothy J. Tehan</u>	
22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Maryland</u>				22e. REC'D BY REGISTRAR <u>DEC 6 1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 12-4-66</u>				23b. DATE THEREOF <u>12-4-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u> </u>	
23d. LOCATION (City, town or county) (State) <u> </u>				23e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				24. ADDRESS <u> </u>			

MEDICAL CERTIFICATION

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